Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON ORTHOPEDIC SURGICAL HOSPITAL
5420 WEST LOOP SOUTH SUITE 3600
BELLAIRE TX 77401

Carrier's Austin Representative Box
Box Number 19

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Date Received
April 24, 2012

MFDR Tracking Number
M4-12-2744-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have request separate reimbursement on implants. Gallagher Bassett failed to pay cost of the implants and the 10% markup in full. Payment is now due in full. Enclosed are the cost of the implants $20,820.55 - $7,691 pmt = $13,129.55 short. No payment was made on the markup $2,000.00. We are also requesting interest. Claim was complete 1/5/12, $15,129.55 at 3.6`% $546.17."

Amount in Dispute: $15,675.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical bill(s) made the basis of this Medical Fee Dispute have been sent back the bill audit vendor for an additional review along with the information provided by the Requestor. I will advise of the outcome of that review once it is available to me."

Response Submitted by: Pappas & Suchma, PC, P. O. Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2011 To October 28, 2011	Inpatient Hospital Surgical Services	$15,675.72	$769.69

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

5. 28 Texas Administrative Code §134.404(g) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 4, 2012
   - W1 — (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - BL — CV: THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM

   Explanation of benefits dated February 21, 2012
   - 19 — (197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - BL — THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL. ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.

Issues

1. Is the respondent's claim adjustment reason code "19 (197)" supported?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care …only when the following situations occur…preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." 28 Texas Administrative Code, Section §134.600(p)(1) requires preauthorization of "inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay." Review of the submitted documentation finds the respondent's initial explanation of benefits denied the disputed services based on W1-Workers Compensation State Fee Schedule Adjustment and subsequently reimbursed the requestor the amount of $16,381.62 on January 4, 2012 under check number 0090630489. The respondent did not clarify or otherwise address the 19 (197) claim adjustment code in the initial explanation of benefits or upon receipt of the request for dispute resolution. For this reason, the Division finds that the 19 (197) claim adjustment reason code is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds that separate reimbursement for implantables was requested in accordance with 28 Texas Administrative Code §134.404(g).

Description of Implant per Itemized Statement	Quantity	Amt Billed	Invoice Cost	Cost + 10%
L/TF6 Cap Price Sys	1	$19,200.00	No Invoice Submitted/Item Unidentifiable	$0.00
ME Infuse Medium	1	$14,679.00	$4,893.00	$4,893.00 + $489.30 = $5,382.30
Crushed Cancellous, 30cc	1	$2,988.00	$597.55	$597.55 + $59.75 = $657.31
Crlk Cap Price Add	1	$5,000.00	No Invoice Submitted/Item Unidentifiable	$0.00
SF DBM 5 ml	2	$7,650.00	$765.00/each	$765.00 + $76.50 = $841.50 x 2 = $1,683.00
TOTAL DUE				$7,722.61

4. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(B) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 517 is $8,730.40. This amount multiplied by 108% is $9,429.41. The total net invoice amount (exclusive of rebates and discounts) for the disputed implantables is $7,020.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $702.00. The total maximum allowable reimbursement (MAR) is therefore $17,151.31. The respondent previously paid $16,831.62, therefore an additional amount of $769.69 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $769.69.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $769.69 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 22, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.